GAPB Public Meeting 2 – Morning Session

-Good morning and welcome to the Ground Ambulance and Patient Billing Advisory Committee meeting.

My name is Terra Sanderson and I will be serving as the facilitator for today's meeting.

We have a number of subject matter experts with us today who will provide information on various ground ambulance and patient billing topics.

Today's session is being recorded by your attendance today.

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Before we dive into the discussion, there are a few logistics that may be helpful for participation in today's session.

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To view the chat box, you will select the chat icon in the toolbar.

We will be taking public comment.

To participate when the chat is open, type your question into the chat box and hit enter.

Please include your name and organizational affiliation when using the chat feature.

Public comments more than three sentences should be submitted via email to GAPBAdvisoryCommittee @CMS.HHS.gov.

We hope everyone has a great experience today.

At this time, I will turn it over to Shaheen Haleem.

-Thank you, Terra, and good morning, everyone.

Next slide, please.

I'll start by just providing a brief background of the purpose of this committee and the authorizing legislation for those who are joining our committee meetings for the first time.

So this advisory committee, the Ground Ambulance and Patient Billing Advisory Committee, is authorized by the No Surprises Act of 2021.

The Federal Advisory Committee Act, FACA, governs the formation and operation of this committee.

We officially announced the committee membership in December of 2022, and we held our first public meeting in May of this year, May 2nd and 3rd.

And for those of you who are joining for the first time, if you wish to access those materials, they are available on the Ground Ambulance and Patient Billing Committee website that is hosted on CMS.gov.

Next slide, please.

So I mentioned the authorizing legislation.

The scope of this committee is also statutorily mandated, set in statute.

The scope of this committee are to review options for disclosure of charges and fees for ground ambulance services to consumers, ways to better inform consumers of insurance options for ground ambulance services, and ways to protect consumers from balance billing.

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This committee must submit a report with their recommendations on those topics to the Departments of Health and Human Services, Department of Labor, and Department of Treasury.

And the report must include recommendations on disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protections and enforcement authorities, preventing balance billing, and also potential regulatory and legislative updates that would allow for enhanced enforcement.

This report is due approximately 180 days after the committee first convenes.

So we will be expecting a report later this fall from the committee.

The GAPB Advisory Committee will not be deviating from the statutorily required topics due to the short nature of their tenure and the quick turnaround for the report.

Next slide, please.

So back in May, when we had our first meeting, two subcommittees were formed under the larger committee in order to pursue specific topics that were arising, particularly in the first meeting.

And these subcommittees are network adequacy and cost payment structures, and public consumer disclosure and coverages.

Today's meeting will focus on the preliminary findings of these two subcommittees and preliminary recommendations of these two subcommittees.

We have posted a detailed agenda for today with the topics at the GAPB website, which you see on your screen here.

Next slide, please.

So public comment.

At this meeting, we do seek substantial public input on the following issues that have come under consideration.

And there are 14 topics total.

I can briefly read through them.

We will also be putting a link or a Word document to download.

These 14 topics are located in the agenda that is publicly posted on our website.

So first topic, should balance bills for ground ambulance services be prohibited as with other services currently under the purview of the No Surprises Act?

Would it be appropriate to incorporate ground ambulance services into existing NSA protections?

Should any protections apply to non-emergency transports?

If so, should those protections differ from emergency transports?

Should any protections apply to assessment, first responder, or other non-covered fees?

How can meaningful public and/or consumer disclosures be crafted?

Should there be cost-sharing limitations for EMS in Medicare Advantage?

Should there be a federal universal EMS benefit?

Next slide, please.

Should EMTs and paramedics be classified as providers?

Should state and local governments specify the out-of-network reimbursements?

Should a public utility model be deployed?

Should emergency ambulance services be considered in-network since the consumer has no choice when they call 911?

We are also seeking information related to examples where consumers have received balance bills from ambulance providers for services not covered by an insurance carrier.

We seek information about what communities or areas in the United States are without adequate emergency ambulance service coverage.

Additional topics are, should NSA protections apply to volunteer ambulance service agencies?

Next slide, please.

So the 14 topics that I read earlier are available in the agenda that is posted on the GAPB website.

You will be able to submit public comment during this meeting using the chat function at specified points during this meeting.

The comments that you put in the chat feature should be limited to about three sentences.

And again, as Terra said earlier, please include your name and organizational affiliation when you use this mechanism.

We highly recommend that lengthy comments of more than three sentences should be submitted via email to GAPBAdvisoryCommittee@ CMS.HHS.gov.

Public comment can be submitted at any time to this email address.

However, we highly recommend that you submit comments on the 14 topics that were listed previously and are listed in the detail agenda by September 5th of 2023 in order to ensure timely consideration by the committee.

Next slide.

I will now turn it over to Asbel Montes, our chairperson.

-So good morning, everyone, and thank you, Shaheen.

But we are excited that you are here.

We're excited for the committee to be here.

And I know the many hours of work that the committee has undergone over the last several months in their public service duty, because this is all volunteer, and this committee has taken it upon themselves to really dissect through the issues, hence some of the public comment and input that we are continuing to seek.

So thank you for that introduction, Shaheen, in here.

We also want to thank our special guest today, and I'll kind of do a review on the next slide over, but we are happy that NHTSA and NEMSIS are here providing us with some much-needed data.

And then we'll talk through how that public comment and questions that the public, and maybe you're not on the committee, and how maybe you can get your questions through that process as well.

And then we will have this afternoon the Office for Civil Rights kind of give us an overview of how HIPAA works and interacts with the EMS industry as that has come up in some topic of conversations and some of our subcommittees on sometimes patients and consumers may be receiving a balance bill due to the interpretation of HIPAA.

And so we're thankful that they're here as well.

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So what I'd like to do is just kind of refresh where we've been.

Shaheen alluded to a little bit about this in her opening remarks as well.

But the committee has been meeting every Wednesday since the May 2nd, 3rd meetings.

And we have put this into two different subcommittees, co-led by Rogelyn McClain and Lee Resnick.

Rogelyn, who is a committee member and representing HHS on this call, CMS, as well as Lee Resnick, who also works with CMS, while not on this committee, has been a subject matter expert that has really provided some much-needed support.

And then we've had another subcommittee also led by Laurent Adler and Patricia Kilmer, who have done yeoman's work putting together and kind of helping to continue to steer conversation.

And they will provide information.

While we may not have recommendations for the committee to deliberate on today, they do have a lot of information, preliminary findings that we have been discussing and some of the involvement that will happen towards the end of the conversation.

So we've actually explored four main areas in these subcommittees.

And those four main areas really center around consumer and provider disclosures, coverages, the cost of ambulance care, and then how local and state regulations impact how the consumer is billed for these charges or these services.

And so that is something that has been explored at length.

It has opened up a window into needing additional input from the public, and hence the reason why you saw those 14 questions.

And we are really asking that when we open up the public comment today, if you've got some public comment, we would love to see that as well as your written comments by September the 5th as well.

In addition to that, there has been a lot of work and a lot of subject matter experts that have presented from our state regulators, from the Insurance Commission to other state regulators, some industry experts from billing agencies that have provided much-needed data to us, federal agencies, you'll hear some of that today, from NHTSA and NEMSIS and some of the public data that is available out there that has actually kind of opened the eyes of the committee on certain things that we might need to address in our recommendations.

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So here's what to expect today.

Right after this, Raj McLean and Lee will kind of start walking through some things as the agenda happens.

We're going to do some new things and Raj will kind of talk about that as we do some committee deliberation on definitions as well.

They'll update us on some preliminary findings and we will open it up for Q&A for the committee at first.

You will see in the chat dialogue some committee questions if committee members have questions.

And then when the time comes for public input, our contractor PRI will open up the chat and then we will moderate the chat and I will be your moderator today to ensure that we have transparency and inclusion throughout the process as well.

And so again, we want to thank you for attending today and then we will stay pretty much as tight to the timeline as possible.

So we have allowed some time at the very end of today if we run out of time for public comment to allow for more public comment via the chat as well.

So this time I'm going to turn it over to Terra since we're right on time with this and we will turn it over to our first presenters.

Terra.

-Thank you.

For our first session of the day, we have Rogelyn McLean and Lee Resnick who are our co-leads for the Subcommittee on Network Adequacy and Cost and Payment Structures and they will be reviewing with us terms and definitions.

-Good morning everybody.

Thank you for joining us.

Again, this is going to be a very active work session where we are looking at terms and definitions that are going to be relevant both to our recommendations and our work.

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So the first thing that we like to do on every activity we embark on is to make sure that we have clarity in our mind on what our statutory mandate is and how that activity relates to our statutory mandate.

So these terms and conditions are going to be important to our role in addressing the statutory mandate of providing recommendations on potential federal, state, and local regulatory and enforcement options for preventing ground ambulance billing and protecting consumers.

And so this is our relevant statutory mandate and you'll see how this work will feed into that.

Next slide.

So the goal of this activity was to arrive at or recommend definitions of terms.

First, for which we should all have a common understanding so that we ensure productive deliberations and recommendations that are clear on their face.

So many of these definitions we're going to talk about may not turn into definitions that we involve in a formal recommendation to the folks that we're reporting to, members of Congress and the secretaries of the Departments of Health and Human Services, Labor, and Treasury.

Others of these definitions will be potentially parts of recommendations and we will discuss why we think as a subcommittee it's important not only that we have a common understanding of some terms but that possibly some terms be codified in order to come up with an effective scheme to address balance billing in ground ambulance.

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Next slide.

So here are the basic terms that we're going to be discussing today.

As we go through them, we will try to explain whether we're discussing this in terms of formal recommendation or whether, again, we just all, you know, need to get on the same page with regard to the meanings of these terms.

And we will try to make sure that we distinguish between the two purposes as we discuss them.

But I do want to call out that as we continue our work, what we intend today may not be what we intend a week from now.

So definitions that we are discussing today and don't necessarily plan to make a part of a recommendation as we deliberate and as we go through our work, that too could change.

So just keep that in mind.

A general note for your listening as we're going through these terms is, like Asbel said, at a certain point we're going to stop for public comment.

So please do us all a favor.

And as you're listening, please note what questions and suggestions you have so that by the time we get to that public comment, you'll remember them and can share them.

We're going to go through a certain run of show.

This is going to be a bit of an experiment for us in live work sessions and deliberations in a public forum.

So please have patience with us.

I just want to describe a little run of show for our committee members and for the public as we go through this.

As step one, again, we're going to identify why we're talking about this term and definition.

And as step two, we're going to try to identify the general issues we're addressing by discussing these terms and definitions.

Step three, I want to make sure that all of our committee members have a chance to weigh in on what they see as the problem or the issue or the topic as it relates to these terms.

And the last step is that we're going to go through and invite discussion on these definitions and actually go through and play with the terms and get input from both our committee members and the public.

So please, when we get started, please make use of your electronic hand.

I've got about three screens going right now.

So I'm going to ask my team to help me when folks are raising their hands so I don't miss anybody.

But let's jump in and see how it goes.

Next slide.

So one of the things that when we get to the feedback part that we are looking for input on, we want to hear your questions, your comments or your concerns about these terms and definitions.

And we'd also like to hear if there are other terms that we haven't discussed that we do need to discuss, including where there are currently codified definitions that for one reason or the other we feel may need to be honed or slightly revised for the context of ground ambulance services.

So keep that in mind as we're discussing it.

Next slide.

So here's our work session.

So PRI, here's the chance that I need to share my screen and we will see how this little experiment goes.

Okay.

So the first term that we're going to discuss this morning -- and let me ask, can everybody see that Word document up on the screen?

Great.

The first term we want to discuss today is billed charge.

For billed charge, at this point, the purpose of us discussing this is for clarity.

But of course, this is one of those that as we go through this work, it could change and become a part of a finding or recommendation.

So one of the reasons that we're talking about billed charges is that many times these terms are used interchangeably and indiscriminately.

You might hear about the price for a service.

You might hear about just a charge.

You might hear about the billed amount.

So what we want to do is set a definition for billed charge so that we all know that when we talk about that term, we all know exactly what we're talking about.

At this point, I'd like to invite other members of the committee to weigh in on the term billed charge and why they think it's important that we have a common understanding of that term.

Would anybody on the committee like to speak on that?

Pete?

-Raj, I see Pete, yeah.

-We can't hear you, Pete.

You may be double muted.

Asbel, while Pete is working that out, do you want to weigh in?

-Sure.

I'm thinking, I know billed charge, from my point of view, I think this definition is pretty clear.

If we're looking at it from a billed charge, not just from our viewpoint, but from a healthcare provider viewpoint, but it really is the charge that the consumer receives before insurance may be billed if they're a self-pay or they don't have insurance or what have you.

I think this would cover it at this point in time, but I think it is important because some people consider billed charge to be usually customary, could be what the charge master from the provider perspective is.

And so, I think it's important that we define or make sure that we're all saying the same language when we're talking about the actual charge for the service before insurance is applied or anything like that.

I see Rhonda has her hand up.

-Rhonda, yes.

-Hi Raj, thank you.

I was just thinking, as Asbel said, we may have some self-insured consumers out there or people who don't have health insurance.

So we might need to add a statement about that as well because this looks like it's just to a health plan.

-Okay.

So Rhonda, let's look at that.

So we want to say the total charges for healthcare service.

So is your suggestion that we also bring in the self-insured plans?

-Yes.

-Okay.

-I don't think she was meaning the plans, the actual self-insured patients.

-Right.

Uninsured consumer.

-Yeah.

-Okay.

To an uninsured consumer.

-Uninsured consumer or a health benefit plan.

-Okay.

-Thank you.

-All right.

Great.

And I wanted to mention while we're discussing, you'll see in these work papers that we have listed references.

And we had our subcommittee members who did yeoman's work in looking for existing definitions for this.

And so, when you see those references, those are either definitions that are codified or that we use to kind of adapt that definition to come up with our working definition.

All right.

Did we get Pete back?

-You able to hear me?

-Perfect.

I can hear you.

Go ahead.

-All right.

Well, first off, thanks, Raj, for putting this together.

You enlarged it, which made it so much easier to see.

Yes.

On this, I agree with adding in, you know, to deal with the consumer.

But should we be worried about whether it's uninsured or anything?

Should it just be total charges for a healthcare service or supply billed to a consumer or health benefit plan?

Does it matter whether it's uninsured?

Because some places, I mean, they may be insured, but we're not able to bill it because it could be that it's out of, you know, out of country, for example, everything's billed to the consumer.

So is the word uninsured critical or should we just be identifying consumer?

-Yeah, I would agree with that.

I think the emphasis is really on the total charge from the provider.

I mean, to whom they're sending it is kind of immaterial so much as this is the focus on where the bill is originating.

-Okay, that sounds right to me.

Rhonda, how does that sound to you?

I think that sounds great.

Yes.

-Okay.

Perfect.

Okay.

Any other comments?

Because you'll see that we're not following alphabetical order and I've kind of grouped them together.

-I think Laurent has a comment as well, Raj.

-Okay, Laurent.

-Thanks.

This is sort of a question for this and sort of the following definitions on things that are, you know, defined a bunch of places in federal code already.

Are we like planning to use this sort of forward-looking writing down anywhere?

Because, if we were writing this in a definition in a new law, there's technical wording on like the health insurance issuer, group health plan or individual, like a specific wording that would just sort of be used.

But if it's just for our internal purposes of understanding, I don't think that's terribly important.

-Right.

And when we get to all of -- you know, this is going to be preliminary work.

So after we finish our work today, we're going to basically get these working definitions out to the group so that folks can look at them again.

And we can talk about things like that as far as where we need to be more precise, especially on those terms that we may be recommending be codified.

-And just building on Laurent's point, that is something, some of these do have existing definitions within the CFR.

I don't know if we're obligated to note that distinction or if we if we want to note that we're, kind of for discussion purposes, adopting something that is different than what's already in federal regulation.

-Right.

And again, I don't anticipate that we will actually vote on these definitions today, but those particular conversations are those that we can have once we have all the input on what the definitions should look like and what we're trying to solve for with the definitions.

Because I think that's going to take, you know, a lot of deep work when we start talking about recommendations for codification.

And so you'll see as we go through this, we are pointing out where there are, especially where we've used NSA definitions.

So that is something that I think we're going to have to continue to talk about as we work on these definitions, because of course, if any one of them turns into a recommendation, we're going to have to explain why we think for ground ambulance, that definition should be different from the definition that's codified.

And then we will have to be very careful about honing and making sure that the language is specific and uses the right terms.

Does that work?

Okay.

All right.

So from here, let's go on to the next term, which is allowed amount.

Here we are referencing again to make this discussion for allowed amount.

We do feel like this term is pretty well accepted in the industry.

And that term is codified.

And so what we are -- it's not codified in this form, but allowed amount is worked into the current NSA scheme for medical services.

But where this definition comes from, and again, here, making sure we're all on the same page, is the healthcare.gov uniform glossary.

And so that working definition would be the maximum amount a plan will pay for covered healthcare service, may also be eligible expense, payment allowment, or negotiated rate.

Now, the reason that we're talking about allowed amount is again, because as you're using that term, you may see it used differently.

Does anybody want to weigh in, committee members, on kind of the issues we see with the term allowed amount and what we're trying to solve for?

All right.

So this one looks pretty straightforward.

Does anybody have any recommendations for revisions, additions?

All right.

Move on to the next.

So the next one we had discussed was patient responsibility.

Again, this is a term that we are addressing to make sure that we are all on the same page and using the same vocabulary.

Patient responsibility can often be confused with balance bills, surprise bills, but we want to make sure that we're discussing this in the context that it is often used in the terms of health insurance.

Does anyone want to weigh in the problems that we're trying to solve with adopting a definition for patient responsibility?

-Raj, I'm just going to make a comment here.

-Okay.

-I think it's really important, and why this exercise has been really important in our subcommittees is this right here, I think, is where it gets confusing for consumers, for providers, and carriers that might be using patient responsibility synonymously with balance billing.

-Yes.

-And so I think this is a really, really important reference point that's already been codified in healthcare.gov that I think will guide the continued work of our committee, especially as we move into the second half of our deliberative work.

So I want the committee to look at this from that perspective and to understand, is there anything that they want to add or amend into it?

So when we talk about balance billing, it's different than patient responsibility.

-Right.

Tricia.

-Thanks.

So this is maybe not particular to this particular definition, but I would say that there's general confusion with a lot of these terms amongst the billed patient population.

And, you know, we could do a really great service in trying to move our ambulance bills and medical bills in general to a more consumer-friendly language.

So you know, sometimes patient responsibility, it's not clear that it's already been submitted to insurance.

If you are insured, it's not clear whether this is the final bill and all of the different charges have come on this final bill.

So I think, you know, as we're moving through these, we might want to then step back and think about these might be what the law or the recommendations for what the law would say are, but then I think it would behoove us to come up with a friendly bill that helps people understand whether or not the amount that they're owing is what they have to pay, whether it's already been run through insurance, whether it counts for their deductible, all of those kinds of things that can cause people to get really confused.

-Right.

And so, Patricia, that would kind of work into our disclosure work?

-Yeah.

But also, I mean, if we are going to codify some of these definitions or borrow, we might want to think about clarifying some of them.

And if there's, like, five or six different, like, versions of it, I noticed one of the definitions said it's also known as this, it's also known as that, that we kind of limit that.

So we can try to get people to talk one language on a bill.

-Right.

Okay.

Well, does anyone have recommendations for our working definition here?

-I see Ritu has his hand raised, Raj.

-Hi there.

Yeah.

So just to support Patty's concern, this is not a very patient-centric definition.

And so I think we should acknowledge that.

I think that it makes sense that we use this definition because that's sort of what the industry uses.

But our constituency, if you will, is not just the industry, but it's our patients.

And this is going to be a source of confusion, I think, for the patient population as they look at our recommendations.

-Okay.

So Ritu, what I hear you saying is that we may need to either look at coming up with a more understandable plain language definition?

-Yeah, I think that would be great.

I just think also that this is the type of definition that is just confusing enough that as we move forward, and especially when we put recommendations out, that we just have to be really clear.

And that's completely the exercise we're going through now, is to ensure that we're clear about what we say.

But even, I think, kind of anything that we put out there, I would almost want to be even more clear that it's this specific definition of patient responsibility.

Because I agree, if I'm a patient and I get a balanced bill, well, that's my responsibility too, right?

So yeah.

-Okay.

-I always just want to be patient-centric in general, too.

-No problem.

-Raj, I think this is probably a good time to get some more public input, because I know the lawyers on the phone and our committee and others, and I'd be interested to hear from Adam as well from the insurance side of it, that I know once you start messing with a definition that is very interrelated with a lot of statutes, it gets problematic pretty quickly.

And so I'm almost wondering if this should go into a more patient-centric in disclosures, and how we disclose to the patient so it makes it very simple.

And I think maybe that's what Patricia was possibly getting at with the consumer-friendly bill that they might receive, and that might be the discussion that we have there as well, and then invite some more public comment on that.

-Okay.

-Yeah, and Asbel, to your point, I think that's why you need to use this definition, is because it's so interrelated to other places and it's sort of an accepted definition.

So I think we have to use it.

I think we just have to acknowledge that it's not necessarily what a patient would call their responsibility.

-I think, Asbel, to your point in talking about, as a public disclosure, I think anywhere we're introducing something new into the conversation or proposing, or as part of our recommendations, offering up ideas for something that doesn't really currently exist in regulation or in the No Surprises Act structure, I think we have a lot more ability there to then kind of start from a patient and consumer-centric approach to make sure that we're using language in our recommendation that isn't as legalese and isn't as kind of intertwined with all of these other intersecting regulatory definitions.

So I think there, when we're talking about something new, we can make sure that we're keeping that patient-centric, and I think that might help the recommendation then ultimately be clear to those that we're recommending it to.

They can worry about the legalese and the regulatory language if and when it actually turns into a regulatory proposal, but for our purposes, I think we want to convey what we're trying to do for consumers and for patients when possible.

-Okay.

Those sound like great ideas, and I think what I'm hearing now is that we're okay with this definition, and moving forward, we are going to work on, you know, a plan for making sure that patients and other laymen that read our report and read our recommendations can clearly understand what we're referring to.

Did that capture it to make sure we kind of capture that future work we want to do?

-I think so.

-Okay.

Perfect.

All right.

-I'm not sure about that.

-Sorry, Alexa has been interrupting today.

So the next one we have is balance bill.

I think, like Asbel had explained before, the issue with this term is that many times the term is confused with a surprise bill.

Not all balance bills are surprise bills.

So what we are working with this working definition here came from the healthcare.gov uniform glossary.

You can see this particular definition is, I believe, more consumer-friendly.

So what do we think about this definition when a provider bills you for the difference between the provider's charge and the allowed amount?

The first thing I was thinking about is, does it need additional detail to distinguish it from a surprise bill?

What do folks think?

Sean?

-Sorry about that.

I think the one thing we might want to consider is that this does not clearly differentiate from cost sharing as we defined previously.

And I know there's one, there's a CFR reference to a definition that does include, I can find it and send it for consideration, but we might just make a note to make sure that we find a definition without recreating the wheel if there's another one in statute or somewhere that makes sure that cost sharing isn't included in balance bills so that the two line up together, the one that we did previously and this.

-Okay.

Okay.

So we will do something that includes cost sharing.

And my recollection when I've seen others, so, Sean, that would be maybe when a provider bills you for the difference between the provider's charge and the allowed amount.

I think I've seen something right around here.

It would say something like, it does not include cost sharing.

-Yeah.

-Okay.

-Exactly.

-And you might want to add -- -It may need more work, so just ignore that.

-You might want to add billed charge since you've defined that earlier.

-Okay.

-If that's what you're talking about.

-Provider's billed charge here.

Does that work, Patricia?

-Yeah, I mean, if that's what you're talking about, because we defined what a billed charge is.

I don't know what a provider's charge is if it's not a billed charge, but there might be a difference.

-Okay.

I'll just bracket that so we can check that.

Laurent?

-Yeah, I was just going to add in, it's probably useful to clarify that it is when a provider not in your health plan's network bills you for the difference to clarify that it's not a network provider can't balance bill you.

This is only an out-of-network provider thing.

-Okay.

-Yeah, and I think that gets at the preferred provider language.

I would just modify to generally refer to a provider that's in a health plan's network since preferred provider can be specific to a particular plan type.

So I wouldn't want folks to kind of look at that and wonder what that means.

-So a network.

-Hey, Raj.

I was just going to say your screen got really big.

-Oh, did it?

I'm not sure why.

-Unless I did something on my end.

-It might be on your end, Pete.

I think it's fine on our end.

-Yeah, it looks fine here.

-Might be just me.

-Oh, okay.

-Okay, I fixed it.

-All right.

-And the only thing I would add to your point that you made earlier, Raj, was distinguishing also, I don't know if we have surprise bill in our definition list.

I can't remember, looking back.

-We do.

It's actually coming up next.

-Perfect.

Excellent.

So we might just want to maybe make a reference balance bill.

Make a reference somehow in there, since this is kind of for a consumer-friendly side of it that we're looking at right now.

-Okay, so we want to make a reference to surprise bill that distinguishes.

-Right, like you would want to know provider not to be confused with surprise bill.

-Okay.

-Because they're used interchangeably.

-Right.

Okay.

Rhonda?

-I've seen some states that are actually putting a statement in there that a balance bill may be a surprise bill because the consumer wasn't expecting it.

I don't know if that's something we want to do, but maybe just look at some other language from various states.

-Okay.

Okay.

Pete?

-Hey, Raj.

-Hey.

Sorry, I was having an issue there.

There is a language in, I think it's federal regulation, that the definition of a balance bill is the practice of out-of-network providers billing patients for the difference between, one, the provider's bill charges, and two, the amount collected from the plan or issuer, plus the amount collected from the patient in the form of cost sharing, such as a copayment, coinsurance, or amounts paid towards a deductible.

And I can get you that language and that citation after the meeting.

-Perfect.

-Okay.

That's 86 CFR 36872, I think is what it says.

-36?

-36872.

-All right.

-I believe that's the citation, but I'll get it to you.

-Okay, perfect.

Anybody else?

Sean?

-This just goes back to a comment, I think, from Rhonda on the statement that a balance bill may be a surprise bill.

And I guess I just want to kind of get a little bit clarified that what we're really talking about is something that, again, sort of distinguishes between cost sharing that would be expected and balance billing that would be unexpected, but that from a consumer point of view, I think they may not even realize they have a cost sharing amount, like a high deductible or a significant copay or coinsurance or something.

Is that kind of what you were thinking, Rhonda?

-Yes, that's exactly what I was thinking.

-Okay.

-Okay.

-And I think, Raj, this goes to the point, again, when we were at that one definition, that's legalese, and it's not necessarily consumer friendly at this point in time.

This dialogue we're having right now is reiterating, because technically the balance bill is really only the amount that does nothing to do with cost sharing or deductible or copay.

And so I think that's really important, what's the dialogue that's happening here that we make sure, because you really are distinguishing between balance bill, surprise bill, which those could be one or the other as Rhonda indicated, but then the definition of the participant's responsibility or the patient responsibility.

That is three different things from statutory that's codified into a lot of statute.

Now, we need to make this, to Patricia's point, very consumer because the consumer doesn't understand that.

Individuals that are involved in all of this understand some of the differences, and even sometimes we don't understand it, we're confused ourselves.

And so I think that is a really good point to make as we start walking through disclosures and then how that interrelates to statute.

-I agree.

I agree.

-All right.

I think we got enough to be getting along with, with working on this definition.

Anything else before we move on?

-Okay.

So going to next would be our definition of surprise bill.

You'll see that I have a couple of reference definitions as well as a working definition.

And I think, again, going over the reason that we're talking about surprise bills is, again, the lack of distinction between surprise bill, cost sharing, balance billing, and the like.

So continuing this discussion and looking at our working definition of a surprise medical bill refers to circumstances where an insured individual receives a bill for services from a provider of ground ambulance services after the patient inadvertently receives services from an out-of- network provider or supplier, including in emergency situations where the patient has no ability to consent to a ground ambulance transport.

You'll see here that we're actually focusing on a surprise bill in an emergency ground ambulance or just in a ground ambulance situation.

One of the things that I thought about in my mind as we are talking about this definition is, you know, getting in there that this relates to people who are insured.

But one of the other things that I began to struggle with was this idea of whether a ground ambulance entity is a provider or a supplier.

So I would appreciate some attention on those terms as we discuss this definition.

So who wants to go first?

-I'll start, Raj.

I want to articulate a statement here that CMS made regarding what a surprise bill is.

And they specifically indicate in the No Surprise Billing and protecting consumers under the current No Surprises Act -- and this is what they say.

In many cases, the out-of-network provider could bill consumers for the difference between the charges the provider billed and the amount paid by the consumer's health plan.

This is what is currently defined as balance bill.

The unexpected balance bill is called a surprise bill.

And so it's a difference between the cost share, the copayment, the deductible, that is the responsibility.

It is the unexpected bill from a balance bill, which is currently defined as the difference between the bill charge and the allowed amount as we already have currently.

And we're talking in legalese, and I know we'll get to the whole disclosures for the consumers and things like that to make it simple for them.

But that is actually currently already defined by the Centers for Medicare and Medicaid Services under the current No Surprises Act piece of it.

And so I think that may be a good reference point for us to start at.

And then does this need some more consumer Friendly?

But that would be my comments on surprise bill.

-Asbel, which rule are you reading from?

The first IFR?

-That's a good question, Raj.

I will tell you.

-Asbel, I think that came from a CMS fact sheet.

Actually, I recall seeing the same language.

-That is a fact sheet on June 14th of 2023.

-All right.

I'll be able to find that with no problem.

All right.

How do folks feel about that definition?

Do we think that gets it, Pete?

-I was just going to go, and I think it may be the same definition you guys just were looking at.

It's in the CMS glossary, and it says surprise billing is when a provider bills a patient for the balance remaining on the bill that the patient's plan does not cover.

This amount is the difference between the actual billed amount and the allowed amount.

-Okay.

I remember that, and I'm trying to remember why we didn't focus on that one.

But, Pete, give me that cite.

You said in the healthcare.gov glossary.

-It's the CMS glossary.

-CMS glossary.

-And I can send you the actual link.

I'll do that.

-Okay.

Thank you.

-Yeah, those might work better for me.

The last part of your working definition, the consent issue, I think, is not necessary and may be confusing.

-Okay.

All right.

-And did we previously in allowed amount, is the cost sharing already defined as being included in the allowed amount so that that kind of clears up that final piece where it's not just the insurance company's actual payment, but it's in allowed amount, but it's also any expected cost share?

-Right.

So here the healthcare.gov glossary references payment allowance.

Should we add in allowed amount here for consumer benefit?

Or do you think payment allowance covers it, Sean?

-I guess for us internally, for the time being, it probably all makes sense.

I just think at some point, we may need to clarify that cost sharing is a part of that allowed amount when it refers specifically to the unexpected bill or balance bill.

-Okay.

Okay.

Noted that.

Okay.

So we're going to go back and kind of start with that definition from the fact sheet.

And we'll have that in our next iteration of these.

-Raj, just a quick comment where you deleted, has no ability to consent to ground ambulance transport.

It just kind of jogged my memory about something.

And maybe this is worth just inserting a comment in the Word file that we may want to define implied consent.

-Okay.

-I don't offer you a definition at this point, but during emergency situations, obviously, for a lot, maybe even most EMS patients, care is being provided under implied consent.

-Okay.

Thanks.

That is a good call out.

Okay.

Anybody else?

All right.

Just checking my time here.

I think we're doing okay.

So the next one for discussion is ground ambulance emergency medical service and the prudent person standard.

So we're going to start with this one.

Just to give the committee an eye into kind of how we came here, we talked about needing a definition for a ground ambulance emergency medical service.

We talked about needing a definition for an emergency service.

And we talked about the prudent person standard.

So as we started to look at the different sources, we're looking at state statutes and the like, EMTALA, all of these things, especially as it relates to what is an emergency medical condition in ground ambulance, really kind of merged into one definition.

And so, I want to talk about that and whether this is where we really need a separate definition for ground ambulance emergency medical service that is completely distinct from the prudent person standard, or is what we're looking at in front of us going to be sufficient for our purposes.

So if he doesn't mind me putting him on the spot, Pete, can you give us a little background for the benefit of us in the public about the issue as it relates to ground ambulance emergency medical services and the prudent person standard?

-Absolutely.

And California has got a very good definition in health and safety code section 1371.5.

And essentially, it says that coverage for ambulance services is to be provided if either there was a medical emergency and the enrollee required ambulance service, or the enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed the condition required ambulance transport.

The issue is, and we had this problem in California in the '90s, is the insurance company started using discharge diagnosis to deny ambulance claims.

If, for example, I called 911 because I was having chest pain and we transported the patient and their discharge diagnosis was undetermined, the insurance company, in many cases, would deny it as not medically necessary because there was no medical emergency determined.

So we put prudent layperson language in place back in the '90s, Assembly Bill 984, that put this prudent layperson standard, which is now, again, it's in health and safety code section 1371.5.

And I think that is a very good and a very defendable definition that allows the patient to call 911 when they reasonably believe that they're having a medical emergency.

Does that make sense?

-I was just pulling up the Cal statute.

-So Raj, while you're doing that, I do want to opine on just a bit of what Pete said here, that if a patient calls 911, it's defined from that perspective.

I think we also need to look at that a patient could be in an emergency room and want transport or getting transport to another hospital.

And in their mind, that to them is critical and an emergency as well if the current emergency room cannot handle their services and need to get them out for a higher level of care.

So think a cardiac cath or something like that that's not provided.

And they may not necessarily call 911.

Somebody else may do it.

A doctor may do it.

A nurse may call and want that patient transported out immediately.

That's sometimes where the confusion gets.

Does prudent layperson apply there?

Is that an emergency?

What is that?

And I know that's probably going to come up in some dialogue as we talk about others.

And so, I would caution us when we're looking at this to tie it specifically to just 911 when we start modifying the definitions of prudent layperson.

-I'd like to add in 911 or equivalent.

Where I work, we try to keep the nursing homes out of the 911 system because the fire department doesn't respond with us.

And so, we give them a seven-digit number that they can call.

And it's equivalent to 911, but it doesn't actually go through a 911 call.

But still, this would apply.

-Okay.

Anything else?

Regina.

-Regina.

Yeah.

-Raj, I want to second what Gary said and Asbel as well.

We need to separate that.

So I like adding or equivalent.

I think that covers it.

-Okay.

Great.

All right.

Anything else?

-Yeah.

The one thing that gives me a little bit of angst on this is when you say was required to treat.

So does that mean that the EMS was required to treat or the emergency department?

And really I would like Pete to reread that definition again because I think I liked it, but I didn't catch all of it.

But it's not just treat, but it's also evaluate if the patient needs to be evaluated.

So I worry if you just put treat in that you're going to limit it to patients who got something.

-Okay.

-So the definition is, again, coverage of ambulance services is there was a medical emergency and the enrollee required ambulance service, or the enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed the condition required ambulance transport services.

-Yeah.

I like that.

-Okay.

And just so we'll have it, I am just going to paste that definition in right here.

So we'll have that.

So that's what the Cal statute looks like.

-And this has been very, very successful for the folks here in California.

Solved the issue right away.

Took us three years.

-Okay.

Ted?

-Yeah, I'm thinking the word maybe should be assessed to match the rest of the Medicare, because there is that assessment component when EMS arrives instead of evaluate.

So required to assess and treat, which would then match the rest of the language.

-So we would go with assess here.

-Okay.

-And I think it's and/or treat.

-Okay.

All right.

So what we'll work on is probably coming back with something that is conglomeration of the California statute with the pinpoints that we kind of worked on today.

Suzanne?

-Thank you and good morning, everyone.

Maybe I missed this.

So the last part where it says include ground transportation of the patient to a hospital or other medically appropriate destination.

When we're talking about other medically appropriate destination, does that -- I know this might seem like oversimplifying it, but does it mean or include inter-facility transportation?

Or is it alternate sites for care?

-That's a good question.

I don't know.

-We can just put that in a list to follow up because -- and I'm not sure, Pete, when you rolled this out, if it was just to handle the 911 ground emergency side of the business, or did it capture that inter-facility piece, which may be someplace else in here that I've got to catch up on reading, but yeah.

-This was 911 specific.

-Okay.

-But I agree with what you guys are saying, you know, from Sean onward that, you know, we need to do that assessment part versus just treatment or transport.

And yeah, there's times that it's a destination that is different than a 911.

We were just dealing with emergency transportation when we got this put in place.

-Okay.

Thank you.

-I think this is what Suzanne brings up that I originally indicated at the very beginning here about this going through 911 or equivalent.

This is where the confusion currently is, and I know this came up in one of our subcommittees, and I believe Patricia brought this up from the behest of a consumer as well, and some of the complaints that they might receive on inter-facility transfers where they think this is an emergency.

Why is it being coded as a non-emergency, or is it being downcoded from someone or another?

And this is where that construct we need to understand in the eyes of the consumer and their belief, if I had a heart attack at a level 3 and I need to get out for a cardiac cath or whatever, is that still an emergency or not?

Depending upon how quickly they responded or what have you, what is that continuation of it through the eyes of the consumer?

And so, I just want to make sure we bring that because I think it needs to be addressed.

-Okay.

Sean.

-Thanks.

I think that one of my comments actually Asbel just covered, but the other one is we also might want to look at the CMS prudent layperson language, just make a note to kind of pop that up, review it, see how they all -- hopefully they should all line up together, but I think we can do that as we move forward.

Neither one are ideal when it comes to the point Asbel just made about inter-facility transfers to higher level care that are often urgent in nature and may not be initiated by a layperson.

So I think that's another subject to tackle.

-Okay.

Okay.

That's great discussion.

I'm just checking our time here.

I think we're doing okay.

So look at there, emergency inter-facility transport.

So Asbel, I know we've already talked about the confusion with inter-facility transports.

So I think we can just kind of jump into this one.

What we came up with was the transport of a patient experiencing an emergency medical condition from one healthcare facility to another as ordered by a qualifying physician or other treating healthcare professional.

I will go ahead and admit here that this is one that we really just had to come up with.

-Here is where -- -Starting from what was out there, but go ahead Asbel.

-Yeah.

Here is where I'm thinking that it'd really be nice to get a lot of public comment on this, and I know we're probably going to be opening up public comment in the next 20, 25 minutes.

But I really feel, because emergency can have a lot of subjectivity to it, and that's what a lot of discussion has happened over the last few months, emergency versus non-emergency.

And maybe we need to have, and I believe in the definitions that you have further on, we're talking about scheduled and unscheduled.

And I'm wondering if it's more appropriate to talk about inter-facility within the context of scheduled and unscheduled from a consumer's perspective.

So if we're going to ensure patients are protected against a balance bill, at what point does it become scheduled and unscheduled?

So scheduled and unscheduled can have very objective terms.

That happens in other healthcare sectors already.

When you get into emergency, non-emergency, and we start into this prudent layperson's definition of an emergency in general from the California to whatever, while it does clean up some, it can still be interpretive.

And so that would be something that, when I'm looking at this piece of it, that we might want to consider as well as a committee.

-Okay.

Suzanne.

-Thank you.

Should we make a note about -- you know, when I read this definition and I hear what, you know, how this came about, and I agree with Asbel as to, you know, scheduled or non-scheduled.

But I do think one thing that's key here that isn't always understood on the consumer side, and sometimes even on the healthcare provider side, is that you're moving somebody someplace else because you can't do it there.

You know, they're going to another facility that, you know, is most appropriate to meet their needs.

And so I just think that, you know, should be weighted.

I mean, my opinion is somehow that should be captured in that conversation.

By choice is a whole different conversation, but by need is a focus we shouldn't take on.

-Agreed.

-My opinion.

-Okay.

Patricia.

-Yes, thank you.

Yeah, I think the scheduled versus non-scheduled might be one way to solve it.

But, you know, I agree with Suzanne that the issue of the patient who either came from the community or their home to the hospital and then finds out that they can't get the services that they need at that place where they were taken, you know, that's one situation where interfacility is definitely needed.

Then there's the situation where a patient might already be in the hospital.

For example, the, you know, pregnant woman goes to her local hospital.

She's had an uncomplicated pregnancy.

She delivers the baby.

All of a sudden there's need for a NICU that that local hospital doesn't have, or some other kind of specialty services for that brand new baby or for the mother who's now maybe experiencing some kind of trauma that the local hospital can't provide.

So you know, in that kind of same situation, I'm feeling like that mother would be calling 911, right?

Like I've got to get my either sick infant or myself, you know, somewhere safer that can actually give me the care that I need.

So scheduled, not scheduled, you know, I don't know if that captures those moments, but those are certainly the situations where people find themselves and just like calling 911.

They're not scheduling that ambulance service.

So that is being scheduled by whatever facility is caring for them right now.

So the patient is set in the same situation and, you know, potentially experiencing that out-of-network transportation that was decided for them.

So I just think we have to think about some of those situations and make sure we're acknowledging the risk of a surprise out-of-network bill for folks.

Thanks.

-Thank you.

Ted.

-I think a key point of also what Patricia's talking about, is the statements on a physician is actually ordering this because they're the ones determining that the facility doesn't have the capabilities for the baby or for other conditions that the patient needs.

So again, you have, obviously, a higher qualified physician making those determinations and requesting the service to be done.

-Right.

Ted, on that point, we have in the definition as ordered by a qualified physician or other treating healthcare provider.

Other treating healthcare provider is really, you know, our language.

How does this work?

The question that was in my mind, is this sufficient to cover or does it happen like things like nurse practitioners may order an emergency inter-facility transport?

-Certainly, in urban and rural settings, that's a big piece of it, right?

You'll have a physician, but you've got nurse practitioners and others that are really determining a lot of that requirements that the patient needs, treating the patient, also identifying where the other locations the patient can be transported to and where those needs are for either stroke centers or NICU centers.

So it's especially teams that have to be identified.

So that's why you've got, I think, a multi-layered approach within the hospital systems where it's not just a physician, but it takes, you know, quite a bit of that to work through as a patient's being determined where they need to go.

-Right.

So do we think that this phrase other treating healthcare provider is sufficient to capture everyone we need to capture?

-You also say it's maybe, there's sometimes a delegated authority that occurs from a physician to the other healthcare provider.

So it can also be in that kind of tone.

-But that's not in every state.

-Right, that's the problem.

It's not.

-In most states, nurse practitioners are independent, licensed independent providers, so they don't have any delegated authority.

And the PAs in some states are, and some aren't.

So it just, I think, depends.

And certainly, I think Ted's absolutely right that, that, you know, you have places where there's a provider like a nurse practitioner in the facility, you know, like a rural emergency department, and they're the one calling for the transfer.

-Okay.

-Yeah.

-So the other interesting thing, having spent -- right now, I'm the medical director of a 911 system, but spent a fair amount of my earlier career as the medical director of a critical care and facility system.

I mean, you can have transfers that would fall under the definition of scheduled, but are still necessary medically.

Like, a patient is in a suburban or rural hospital where a certain procedure is not available, and it doesn't need to be done that day.

But maybe it needs to be done tomorrow or the next day, so that they would schedule the transfer to be more timely with the procedure.

Certainly, some orthopedic procedures might fall under something like that.

And so, my concern is still that the patient has this unmet medical need that needs to be taken care of, and that, you know, that they shouldn't necessarily have the risk associated with that, just because it was scheduled for two days from now.

There are also cases in, like, the neonatal world where that might happen too.

Just to build on Patty's example.

-Okay.

So if we could, at this point, because I think I'm hearing that the working definition is a decent starting point, we need to look at our bullet points here.

But at this point, let's go down to scheduled and unscheduled requests.

Again, these are ones that we really just came up with, because as we research this, we now know why there's so much confusion, because we could not come up with an existing definition for scheduled and unscheduled.

So how do we feel about these working definitions, and where do we need to start?

-So I think that we could probably take the context around the No Surprises Act and the current notice and consent provisions as they're currently define to other healthcare providers when they can actually do notice and consent.

And I'm not talking about should we allow, and is it applicable in our situation as ground?

I'm talking about in general, if you look at the notice and consent provisions, and when they occur, there's timeframes that are given.

And so, you know, if it's an appointment that was scheduled within 72 hours, you know, there's some definitions around there.

And I'm thinking, if I was going to look at it in the context of a scheduled or unscheduled, it's going to be in a timeframe.

What is a timeframe?

Is it three days?

Is it five days that you consider scheduled?

If it did, it would be unscheduled, and then that would correlate with something.

So if I was going to look at scheduled versus unscheduled, it would be something similar to how notice and consent is currently done, because in some positions, the patient isn't informed.

There's a transport, whether it was a day later, because it was a part of their condition for higher level of care, could have been higher level of care, but it was two days before they could get to that higher level of care.

If they didn't get to that higher level of care, they would medically deteriorate and turn back into a 911 call.

So it's a part of that could possibly be in context of post-stabilization.

So if I was going to look at this, that's kind of where I would start first to see, is there a general theme that could be developed into a scheduled or unscheduled if we pursue this venue?

-Asbel, one question I had is this concept of scheduled and unscheduled as it relates to an emergency or non-emergency.

You'll see that just based on what we came up with.

And I think what I'm understanding is that scheduled and unscheduled isn't always about an emergency or, you know, in an emergency situation.

Can you talk to me a little bit about scheduled and unscheduled as it relates to emergency services or those emergency transports?

-So I would usually look at this in context.

I think Ritu gave a really, really good example of someone maybe being on the floor.

They were admitted for a reason and they needed services from some other facility.

You know, sometimes they're coming out of an emergency room, going for a higher level of care.

Oftentimes, more than not, that's a part of it.

The doctor's going to order if they don't get the services.

But say, for instance, they're on a floor, they need to be scheduled tomorrow.

But if they don't get that, there's going to be a critical issue begin to happen.

In that instance, it could be a continuation of an unscheduled environment because can you get to it?

They're scheduling.

Case management is looking at it.

It may take them seven or eight hours or 10 hours to locate another facility to take the patient.

And so, sometimes if you put a timeframe parameter in, because people have played around with six hours or eight hours or nine hours, but there's situations in there.

And if you come with a definitive -- I like to go back to how we look at ambulance in the world of repetitive transports, which we have repetitive non-scheduled or a repetitive scheduled non-emergency ambulance transportation for dialysis.

And basically, those are things that are scheduled.

They're continuing on.

You know it's going to happen on Monday, Wednesday, Friday, Tuesday, Thursday.

You know it's going to happen at 10 o'clock or 2 o'clock.

And it's a repetitive happening all of the time.

But can you really do anything around noticing consent provisions for a patient that's in a hospital and the doctor needs to discharge them quickly, whether they're going to rehab or something like that?

And they've got an hour or two hours and the ambulance needs to respond and be active and ready, just like they are in a 911 situation.

So is there any difference in cost associated?

Is there any difference with anything else, whether it was a 911 call that you needed to have 24 set or you, it was a discharge to go to rehabilitation or rehab for something where a case manager calls or an emerge says, we need to get this patient moved now.

And so, that's kind of the context that sometimes gets a little unclear where it becomes very subjective and different ways that it's defined, which then produces a balance bill to a consumer that doesn't understand.

And they look at it and they're like, well, this was an emergency.

If I didn't go there, this would have happened.

And so, that to me is kind of where I think there's confusion and we need to define that.

-Okay.

Okay.

That helps.

I think we have a lot of work to do.

Patricia, go ahead.

-Thank you.

Yeah.

And so, not to make it any more complicated than it already is, but the issue of you know, if we're making this distinction, it worries me a little bit that there might be, you know, some limits to the surprise billing protections.

But if there's only one ambulance company that provides the transportation in that community, scheduled, not scheduled, whatever, the patient is still going to be subjected to that out-of-network bill if that one ambulance is not part of their network.

So who's making the decision to transport them, how far in advance, whatever, it's still a situation if there's only that one company and it is out-of-network that you would be facing an out-of-network surprise bill that you have no choice over.

You can't make the choice to go in-network.

So I think we just have to keep that in mind.

You know, I'm not sure exactly how we might use some of these definitions, but that's just something that will be out there that I'll just keep raising.

And we'll talk about it later this afternoon in our presentation.

-Okay.

All right, Rhonda.

-Yeah, I just wanted to say I think we need to be really cautious with certain timeframes.

And I know that, you know, in our ED, we can call 30 hospitals trying to get a patient transferred out, and sometimes we have to board a patient in the ED for multiple days, but they're still needing a higher level of care.

So I just think we have to be really cautious about putting timeframes around what would be allowed and what wouldn't, whether it's scheduled or unscheduled.

-Okay.

Okay.

Anybody else on this scheduled and unscheduled?

Looks like we have a lot of work to do here.

All right.

So now I'm going to go back up and go to our next, which would be the post-stabilization ground ambulance services.

So if someone could give us some background on why we are addressing this definition, that would be helpful.

What is the issue with post-stabilization ground ambulance services?

Asbel?

Oh, Rhonda.

-Well, I was just going to say I think that this goes more towards the scheduled.

So the patient has been stabilized, and maybe they need to be discharged to a rehab facility or back to a skilled nursing facility.

They're not able to have private transportation.

So I think that in my mind that this goes along towards the scheduled ambulance service.

-Okay.

-So the only thing is, and I'm not sure who made the suggestion on this post-stabilization ground ambulance, but I believe this CFR reference is tied to that ENTALA piece where the patient came in for an emergency medical condition, and then this is a part of the post-stabilization part of that, Raj.

It's very similar to what we're talking through, the emergency inter-facility transfer.

The patient is being -- if this is the right reference, this could be almost synonymous or closely aligned with what we're talking through on the other definition of emergency inter-facility as well.

I believe that's what that 438 is, but I'm not sure.

I'll have to go back and look at it.

-And then this gets into existing No Surprises Act implications that I think we would want to just be cognizant of that, you know, under the existing statute, the No Surprises Act does apply to many post-stabilization services.

And there's been questions, I know, at least in two states where state departments of insurance have interpreted intra-facility transfers as post-stabilization services where then they're trying to apply No Surprises Act rules to ground ambulances in the intra-facility transfers.

And I think at least one where they've tried to apply that in inter-facility, it's claiming that it falls under the No Surprises Act emergency services definition that includes post-stabilization services.

So there's just a lot of interplay there that I think we're going to in any recommendations need to kind of note where we're talking about existing No Surprises Act regulations and where we're kind of going into new territory.

-Okay.

-Ted has his hand raised.

-Yeah, I think just also just making sure we realize that there's some previous statements.

It's when a person actually needs an ambulance for transportation, you know, so this is somebody that needs oxygen, needs medical monitoring, you know, there's components where it is that it's, you know, it's well above that claim of, you know, potentially patients need to be discharged in a personal vehicle.

There's a reason why the person is going between facilities and how the states obviously manage that also within some of the rules on be it oxygen, you know, move a patient appropriately for hip fractures, you know, things like that that still require true patient treatments in ambulances and monitoring.

-Okay.

Okay, anybody else?

All right.

There, what's next?

We've done scheduled and unscheduled.

-Raj, while we're doing that, in the last 30 minutes as we continue to keep deliberating, I'm going to ask PRR to kind of open the chat box.

So if any of the public has any comment, they can start making comments and then we can see if there's anything that we're missing in conjunction prior to September 5th as well.

-All right.

Great.

So the next one we have before us is a definition of community paramedicine.

I think at this point, our goal with dealing with this definition is still in flux.

But what I'd like to do is invite Gary to talk to us a little bit about community paramedicine and basically why we're looking at this today.

Gary?

-Yeah.

So community paramedicine is a not covered service under Medicare currently, even though many insurance plans and Medicaid managed care have it covered.

So it always results in a balanced bill.

After the subcommittee got this list this morning, I emailed the subcommittee back with a definition that went through an international consensus process that covered several different countries.

-Okay.

-And it is a community paramedic provides person-centered care in a diverse range of settings that addresses the needs of the community.

Their practice may include provision of primary healthcare, health promotion, disease management, clinical assessment, and needs-based interventions.

They should be integrated with interdisciplinary healthcare teams, which aim to improve patient outcomes through education, advocacy, and health system navigation.

So it's a little more expansive than the one we have.

And maybe we could look at merging them or using the consensus definition that was done in a research project and published.

-Okay.

-And so, Gary, just to reiterate what you shared with us, again, community paramedical professionals are currently, I understand, Gary, generally not compensated to the extent that they work in connection with ground ambulances.

Or is that true?

Do they have a role and a life outside of a ground ambulance service?

-Yeah.

So the services can be provided by an ambulance service or in other models.

We currently in the United States have direct-to-consumer community paramedicine models.

An example, I don't know all of the systems.

There's several of them, but MedArrive would be an example of that.

And some of those systems outside of an ambulance service are direct contracting with insurers.

Some of them get lists of patients that a Medicaid managed care plan wants seen because they've gone to an emergency room and have never had a primary care physician visit.

And so, it can be in a lot of models.

There's hospital at home.

There's just a lot of models where the care is provided.

But because it's not a Medicare-covered service, if you're on Medicare and you need and use these services, then you get a full bill.

-Right.

And so, I want to make clear for everybody listening while we're discussing community paramedicine.

Again, we're going to get into how balance bills relate to these type of thing when we talk about coverages and disclosures and the like.

But here, community paramedicine, my understanding of why we're speaking to this is because the lack of coverage for these services is often going to result in a ground ambulance responding and eventually not necessarily getting paid.

And Gary, I feel like I'm messing this up royally.

So please jump in here.

But I want to make sure that the public understands while we're talking about community paramedicine that is currently not a public service and how that can lead or exacerbate the fact that it's not covered, how this could contribute to balance bills for ground ambulance.

Gary, can you better make that connection for me?

-Yeah.

I think you did a pretty good job.

Not having access to it may or may not result in an ambulance being dispatched.

So for example, they may get a referral from a physician.

The community paramedicine service may get a referral from a physician to see a patient and do specific things that might include things like lab draws, if they can be treated at home to get their IV antibiotics, those kinds of things.

But it's non-covered.

And so that's the patient protection piece here.

It's covered in many places in insurance companies and especially in Medicaid managed care, at-risk organizations, favor community paramedicine.

100 research papers on how it reduces healthcare downstream costs.

And so, it's well-supported in research.

But because it's a non-covered benefit, the patient protection is that the patient 100 percent of the time would get a full bill because it's not covered at all.

So the recommendation is to make it a covered service.

And so that can protect the patient from getting those bills.

-Okay.

Appreciate it, Gary.

So now I'd like to move to the paramedic intercept.

I think this is another definition that we're looking at for similar reasons that we're looking to the last definition we discussed.

Ted, could you talk to us a little bit about this definition of paramedic intercept and why it's relevant to our deliberations and activities?

-Yeah.

Communities, a number of states, it's actually in some Medicare, let's say New York.

I was actually practicing paramedic there in New York and ran a paramedic intercept model where you've got paramedics in fly cars and QRVs or Ford Explorer type vehicles responding out to meet incoming ambulances to the potentially more urban centers.

So you have it where you've got either EMT ambulances or volunteers and it provides a higher level of care for those communities.

So you may have a 45-minute or an hour transport time and the paramedic will actually intercept with that ambulance and then upgrade that ambulance from BLS to ALS and it gives the capabilities then for, you know, obviously reimbursement for that type of clinical care that's being done.

And that's just one of the options there.

-Okay.

Pete?

-And yeah, this is, you know, an old definition that was really designed for a specific issue, you know, the upstate New York issue.

But it falls into one of the other definitions that I had, or the terms I had put in the ALS first response, where the paramedic intercept ALS first response, we've got ALS services being provided by an entity that doesn't provide the ambulance transport.

And Asbel and I had a pretty long and I thought a good conversation on it to kind of outline the needs here.

Because in many cases, this results in a bill being issued to the patient that is not covered by insurance.

Because if you have a fire department that provides that ALS first response service, it's a non-covered service.

And then paramedic intercept is only covered in upstate New York.

And I don't even know if that applies anymore based on some changes they've made to allow billing.

But we have to evolve the system and the reimbursement to keep place with it.

Sorry, the system's evolved.

We need the reimbursement to keep pace.

ALS first response needs to be defined and recognized.

And we need to come up with a mechanism that we can get NPIs, the National Provider Identification for these non-transport agencies that are providing paramedic level care, but not ambulance transport.

And I think that's a conversation that we need to continue to have so that patients aren't getting bills that insurance companies in many cases will not cover because they say they have no NPI.

-Right.

Okay.

So now I want to make sure we have at least, you know, 30 minutes for our public comment.

What we have left are treatment in place, cost, and price.

Treatment in place.

This is, again, another definition that we're talking about as a subject that often leads to a consumer getting a bill because many times treatment in place, if a ground ambulance does not actually transport the patient somewhere to that healthcare facility, to that hospital, my understanding is that they are not paid.

So this often results in a bill.

Does anybody else want to talk a bit about treatment in place and why it's important to our work today?

-Yeah, I will, because I know this is probably going to come up in some of the coverages, discussions, and disclosure of non-coverages, but I think we probably need to expand treatment in place.

I believe you're taking it from the Centers for Medicare and Medicaid Innovation that we had them present to the committee several times, but this could be synonymous with treatment, no transport.

And I know NHTSA and NEMSIS's data will talk about like treatment, no response, treatment, no transport, treat and release, things like that.

So we probably need to -- very similar to how you have that bill charge that could include this and this and this, and it's referred to as whatever.

We probably want to do something in there if we're going to come up with a definition of whenever an ambulance responds or somebody calls 911 or the equivalent, there is a response, somebody shows up on scene, assesses, it could be referred to in several different ways, but in general, it's a non-covered service.

-Okay.

-Not all the time, but in general, it is.

-Right.

And Asbel, do I recall correctly that whatever flexibilities were put in place during the public health emergency have now expired?

-For the limited treatment in place provision that was passed into the public health emergency, the ET3 or that emergency triage, transport, treat -- sorry, treat -- -Triage, treatment and transport.

-There we go, sorry.

Triage, treatment, transport will expire 12-31.

-Okay.

-And so that as a provision, if you were part of this demonstration program, there was some coverage portions of that under the current Medicare program, but that will expire as of 12-31.

But generally speaking, when we start talking about, is there any instances where patients might receive a bill for non-covered services, this potentially could be one of them.

We are getting subject matter experts, Raj, of course, that are coming to talk from some plans that are covering certain things and why they cover it and in what instances they currently cover it.

So the committee can kind of understand that piece as well when we start formulating either findings or recommendations, just depending if it's within our charge or not to make a recommendation.

-Okay.

So I want to move quickly to cost and price.

-Oh, wait, wait.

-Oh, sorry.

Sorry, go ahead.

-No, I just want to reiterate something I brought up when we've talked about this at our other meetings, but from the physician community side, we're very supportive of the concept.

Obviously, a large percentage of our patients don't get transported, but we also feel like this is really an important place to have strong guardrails around quality and medical oversight.

-Okay.

Okay.

Anything else, Ritu?

All right.

So quickly, our last two definitions are cost and price.

And of course, these two definitions that we originally focused on, again, so that we can make sure we're all speaking the same language.

This first definition, this working definition is basically we would basically recommend that the costs that were recorded and defined in the Medicare ground ambulance data collection system, you know, be adopted for purposes of our defining costs.

Is there someone on the line that can talk about those cost elements?

I did fail to paste those in.

Could somebody talk to us a bit about that and what those, you know, representative lists of those costs that are considered in this system?

-Well, maybe I'll jump in, Raj.

Basically, you have buckets that include all of the things that go into the infrastructure of operating an ambulance service to be ready to respond.

So things like your personnel, vehicles, facilities, administrative team overhead.

And then you have a certain amount of incremental cost that would be incurred on a case-by-case basis, such as your disposable medical supplies, pharmaceuticals, et cetera.

And then for accounting purposes, you have costs such as depreciation of assets and other things that would work in there.

So that you end up with a comprehensive look at everything, all the financial resources it takes to be ready to respond to a call, which is a key component there as volume can vary considerably and ambulances are different from, let's say, a clinic that maybe you can schedule a full day or if you only need to work three days a week in a community because that's all the volume there is, you don't have your staff in there the other two days and you shut down or you only rent a facility for a part-time basis, things like that.

So ambulance service costs, reporting, data collection, excuse me, to be correct on the terminology, is really about understanding that cost of readiness and then looking at how that relates to the revenue generated by the volume that a community creates for that ambulance service.

To come up with an actual cost per service rendered, you need to look at both halves of the equation.

-Right.

-Others, please chime in.

-This is Pete.

I think, you know, to build off that, we need to continue to recognize that it's just identified.

We don't get to choose when we're going to be in service.

We have to be in service at 2 a.m.

in the morning and we have to be in service at 2 p.m.

in the afternoon.

We have to cover Christmas and we have to cover the 27th of September.

It doesn't matter.

That's the thing is there's requirements for the provision of service, 24 hours, and there's response time requirements and there's penalties.

There isn't just, you know, the ambulance services, the private companies in particular, they're subject to penalties when they cannot meet the response time requirement.

So they have to ensure that they have the ability to do it or it causes problems in the system.

And that's a cost of readiness that's key.

-Ted?

-And also that costs are different by community and by requirements that counties or states or even local operation requirements are set up for.

So how many ambulances cover a geographic area may be different in one community than another.

A number of paramedics potentially on an ambulance may be different in one community than another.

So you end up with somewhat of a different cost structure among some of the providers.

But that usually is customized quite often for what that community's need or requirements have been established over a period of time.

-All right, Gary.

-Yeah, and I'd also like to point out again that the rural communities often don't get enough reimbursement to have staff, paid staff.

And that's an issue as recruitment and retention of volunteers is getting very worse.

And so, there's a consumer protection hook about here, whether you have an ambulance service at all.

And I think there's also a piece that relates to negotiating contracts with insurers.

Oftentimes, those are presented as take it or leave it.

And there's no opportunity for the ambulance company to open their books and say, here's our cost.

And now let's talk about the reimbursement based on our cost.

Rather than accepting Medicare rates or 150 percent of Medicare, whatever it might be, the negotiation between the ambulance company and the insurer needs to occur and should be based on the costs that Pete and others, Tron, described really well.

-Thanks, Gary.

That's the exact point I wanted to make sure that we made for everyone here listening to the meeting, is that the reason that costs are important to our activity is because of the current way that many ground ambulance services are reimbursed, and the fact that they do not receive reimbursement for many of the services, resources on the transport, like drugs and other medications.

So why this is important is if an ambulance services cannot cover its cost, the availability of that service to the public is threatened.

So it seems that based on what we've been learning since this committee has been together, is that ambulance services are by and large reimbursed as a transport service.

So you're kind of getting a base rate plus your mileage, and everything that that ambulance service actually has to provide, whether it be because of state or local rules or federal rules, everything they have to provide has to be covered by whatever they're being reimbursed, or maybe those costs are covered or not covered by going in the red.

So I just wanted to make that point, and Sean, maybe you can make that point better than I can about why it's so important that we understand the cost incurred by different ambulance providers.

-Well, and I think actually you just, you really did sum it up well, and I guess the only other thing I would add is that when we talk about what those kind of requirements are that all get wrapped into that single base rate and mileage, those requirements are set by authorities who are looking at national standards and national practice models.

And I think Ritu can probably speak to that, both as a system medical director, a regulator, and a physician in the national EMS community, that while there may be some subtle differences between how a community treats a particular medical condition, those are driven by looking at national best practice models from medical systems around the country.

-Right.

All right.

-So I think just, Raj, from this perspective, we're doing definition and we're getting caught in policy or whatever, but from the cost piece of it, I agree with Sean here that I think the Medicare ground ambulance team did a really good job, and we could put those categories in there, of identifying what is cost for ground ambulance providers, and then we can then take that to use for policy recommendations.

-Perfect.

All right.

Very quickly, we're going to go to price.

Price is one of those definitions, again, that we wanted to arrive at so that we're all speaking the same language.

We started with a dictionary definition of price, and we came up with the amount of money a supplier accepts or agrees to accept in exchange for providing ground ambulance medical transport services to a patient inclusive of related charges, including gas, mileage, drug supplies, et cetera.

This one, I don't know if we want to get in too much here because I really want to get to the public comments on these.

So if we can, for this price, this is one that we'll handle offline, but for purposes of the public and public comment, know that we are trying to make sure we're using the same definition, because a lot of time, cost and price are mixed up, and so we're trying to make the distinction between what cost an ambulance supplier has to expend to provide the service, and the price is basically their sticker price for their services.

Does anyone want to say anything about price quickly?

Seems to be a pretty straightforward one.

Asbel?

-No, the only thing I'm going to say is we'll discuss it when we kind of move into the next half or what have you, but the inclusive of related charges, including gas, mileage, drugs, or whatever, could be problematic when we're looking at price.

-Okay.

Got it.

Okay.

So I'll mark that so we can look at that.

All right.

-And I know there's been people putting stuff in the chat, but just as a matter of time, because, Raj, we have about five minutes until we break.

-Oh, I apologize.

I thought we were going to 11:45.

-We're going until 11:30.

-Apologies.

-No, not at all.

Not at all.

-All right.

So I have not been reading the chat.

So Asbel, do we want to invite folks to weigh in?

-I will tell you this.

We've been getting numerous comments in here.

Some of them are related to definitions, of course, around inter-facility emergency immediate response, and there's been some really, really good comment here that I know we'll record and continue to deliberate on.

I believe there was a few comments, one from a service up in Illinois that talked about inter-facility transfers that they do that are a lot unscheduled, going for higher level of care.

And I think we're kind of alluding to that in that emergency post-stabilization, maybe higher level of care needs to be considered when we're thinking through those processes.

I know there's been comments on, does it cover lower level of care, higher level of care?

And so, I think we've got some good comments here.

I'm going to suggest, if you want to continue to provide input on that, at the very end, don't forget, we will have more time for public comments.

So that might give us some time here too, Raj, at the very end of the meeting this afternoon, to maybe get some clarification if there's something in those comments that we need.

But it looks like some of the comments coming in right now, we're covering and making points to continue to deliberate on.

-Yes, yes.

And thank you for those.

Very helpful.

-Sean, I see your hand's raised as well.

-Yeah, just for the committee, will these comments be put onto some kind of format and redistributed to us so we can read them all later?

-I'll let Shaheen opine on that from the procedural standpoint, but yes, they will be.

Shaheen?

I know she's not there.

They will be transcribed, and they will be also available to the public, as well as in the first public meetings.

-Yes, this is Shaheen.

I'm working on getting another web request to post the meeting materials, and we expect to have the slides and the definitions, the working definitions posted early next week.

-Jim Ryber just made a comment about Blue Cross refusing to contract with them because of the volume they have.

So that's not part of the subcommittee that I'm on, but I wonder if that has come up with in the other subcommittee as an issue of the insurer refusing to contract at all.

-Sure, and we will probably bring that up, Gary.

That's a really good public comment when we get to the very end.

Right now, we're trying to keep anything about definitions and anything that maybe we have not included in the definitions that would need to be clarified as we continue to deliberate around the No Surprises Act charge.

So we do have another minute.

One more question from Pete, and then we're going to turn this back over to Terra to start our break because we do have a presentation following right after, and we want to be cognizant of our speakers.

Pete?

-Thank you.

For Raj, I had sent some other words or some other terms for definition back in June.

How do you want to get those?

You just want me to send them again as I have to consider?

They were like ALS first response, alternate destination, direct reimbursement, et cetera.

How do you want me to get those back onto the list of terms to be discussed?

-Yeah, just send those to me, Pete, and we'll add them all.

-Okay.

I will get those sent off to you when I get back.

-Okay.

-Thank you for that.

This is a general thing for the public as well.

Continue to submit your comment, and do not forget about the written comments that are by September 5th as well, and we'll close the meeting with that as well, and I'll turn this over to Terra.

-Okay.

Thank you, Raj.

We will now take a 10-minute break and resume at 11:40 Eastern Time with Session 2 from our NEMSIS team.

Welcome back.

As a reminder, public comment will be available to be submitted via the chat feature at specific times today, so we ask that you use the chat feature to submit your comments, and we will begin back with Session 2 this morning.

We have Eric Chaney and Clay Mann from the National EMS Information System.

Eric Chaney is the Program Manager, and Clay Mann is the Principal Investigator for the NEMSIS Technical Assistance Center, and with that, I will turn it over to Eric Chaney.

-Good afternoon, everyone.

Thanks for the opportunity to be here today.

Can you hear me okay?

Excellent.

Thank you, ma'am.

So we were provided with some basic questions to get started with, and we've prepared some responses to those questions.

We'll start down through the presentation.

If you have questions, I'm assuming we want to take those with the slide that we're looking at because, you know, some of these are going to get kind of detailed and you might forget, so please let's take the questions as you go.

Just jump in, raise your hand, or let us know what your question is, and we'll move forward.

Next slide, please.

So overall, I just want to set -- -Eric, you went on mute.

-Sorry.

NEMSIS, thank you.

NEMSIS is a data standard that's established for all of the ambulance services in the United States.

So the data that we're going to talk about today, when we talk about ground transport, it's defined the same way in the 14,000-ish ambulance services in the U.S.

So everybody understands and recognizes that term, that definition.

It's in a very detailed data dictionary that you can look at in NEMSIS.org, and I want to talk about the data set itself very quickly.

NEMSIS has about 585 data elements that could be captured at your agency level, your ambulance service.

Some ambulance services capture the bulk of that data, and some only capture 535 of those data elements, and a good example is billing.

An ambulance service that does not bill would not capture the data for billing.

It would not use those data elements.

Once that service identifies that data, they collect it.

They then send a subset of that data to the state, often because of a statute that says you have to provide us with this data, and the state is usually very specific about what data elements they want to collect.

So out of that 585, the state may only take 400-ish.

It depends on the state, and in some cases, the state may take billing data, and in other cases, they may not.

Then a subset of that state data is then sent to the National EMS Information System, the National Repository, and that's about 165 data elements, 185 elements.

They come to the national level.

So as we talk about data availability, regardless of what it is, some will be available at the agency level, some at the state level, and then some at the federal level, and it's based on statutory authorities or

based on just the way the system was established in the beginning, and we'll talk about that as we go through.

So we're going to look at 2022 NEMSIS data for this presentation.

That represents about 51,400,000 EMS activations throughout the United States, and activation is not necessarily a patient encounter.

A lot of EMS responses result in no patient found or the patient is going on arrival.

There's numerous reasons why an activation would not lead to a patient, so don't confuse the two.

Fifty-three or 54 states and/or territories provide data.

All 50 states, three territories, and the District of Columbia.

That's what makes up the 54 states that we have listed.

So for the purposes of what we're going to talk about, this is the breakdown of all of those 51 million calls that you could look at in NEMSIS.

There's ground transport, which is my understanding the purpose of this committee, 46 million activations.

There's non-transport administrative, non-transport assistance, non-transport rescue, and then helicopter and fixed wing.

For everything I'm going to talk about from this point forward, it is specific to the 46 million number that's there.

Ground transport, we've excluded everything else.

I'm assuming that that's acceptable, unless I hear that's unacceptable.

Okay, excellent.

So you can go to the next slide, I'm sorry.

-Can I ask a question, Eric, on that slide?

-Yes, sir.

-Can you just confirm for me that the activations does not necessarily -- so if I look at that ground transport number of 46 million, that does not equal patients from a consumer perspective.

-Right.

-So it's not like 46 million consumers may potentially get a balance bill, correct?

-That's correct, and that's exactly what we're going to look at in the next couple slides.

We're going to break that number down further for you to look at, but you are absolutely correct.

Next slide, please.

So if we look at that 46 million, we look at the percent of calls that are not transport, and what Clay has done is highlighted in red those categories that are resulting in non-transport.

So these are the categories that you could select as having done something as a part of an activation, and if you go down about three quarters of the way, you'll see 33 million of those were patients treated and transported.

So out of the 46 million that we started with, 33 million resulted in a patient being treated and transported by EMS.

So let's look at non-transport.

That's the purpose of this particular slide.

The result of patients -- the bulk of patients where there was no transport were patients that refused evaluation or care, and patients can do that with EMS.

We arrive on scene of a motor vehicle crash, patient says, I'm fine, it was just a fender bender.

Law enforcement called the ambulance as a part of protocol or 911 dispatched it as part of protocol.

We got there, patient refused evaluation, just get away from me, we don't need anything.

That represented 4.6 percent, or about 2 million.

Then there's this patient treated and released AMA, that's that motor vehicle crash patient that hit their head on the steering wheel, has an obvious contusion.

For whatever reason, the paramedic says, hey, look, you should really go to the hospital, you know, the airbags deployed, this met our protocol for transport, and the patient still says, nope, I'm fine, I'm not injured, I don't need anything.

That would be an example of AMA.

And then patient could have been treated.

They had minor abrasions, they fell off a bicycle or something, EMS was called, and they provided some bandaging and bleeding.

That represented about 1.71 percent.

So you see the patient treated where we actually had interaction with the patient.

We may or may not have provided treatment, but then the patient wasn't transported to the hospital.

Those are the 4.6, 3.64, and 1.71.

Let's move up a little bit to the patient dead on scene.

That's a possibility as well.

And there's two categories there really for that.

Patient's dead, resuscitation was attempted, and patient was dead and no resuscitation was attempted.

And you see the breakdown there.

In some cases, there's transport with that resuscitation.

In other words, the paramedic got there, they attempted resuscitation, they could have called it in the field, that's one option, and say, okay, we're not even going to try to transport this patient to the hospital.

We contacted MediControl, this patient is dead at the house, and we're no longer going to try to resuscitate the patient.

The other category is they start resuscitation in the house, they transfer the patient to the ambulance, they continue the resuscitation en route to the hospital.

That's another option as well.

Then at the top, there are three categories for assist.

Assist agency, assist public, and assist unit.

These are really kind of catch-all categories that could be anything from standby at a rock concert to standby at a medical incident where there was a second ambulance requested, but there wasn't a need for care from that second ambulance, to just a public assist type of call in general.

They're the catch-all categories that may or may not result in a patient, most likely not, and there's no transport out of that, obviously.

So that's the breakdown of that 46 million calls or activations where there was no transport, and I'll stop there and take any questions.

All right, if there's no questions, we'll go to the next slide.

We can always come back.

So then the percent of non-transport calls that receive treatment in place that was discussed earlier, the treatment in place definition.

So for patients that receive treatment in place, but then were not transported, there are really two categories here.

Patient was treated and released AMA, or the patient was treated and released per protocol, or medical direction would fall into that category, too, and that represents about 2.5 million patients out of that 46 million active calls of activation or EMS activations.

We'll go to the next slide, please.

So the most common reasons for non-transport, refused, expired, you know, care wasn't required.

You see the public assist, the agency assist, and unit assist in the top categories.

Again, most likely not a patient, just assist with other services.

But the most common reasons for non-transport was the patient was dead on the scene and no resuscitation was attempted.

So this person was obviously dead.

The patient was dead, and resuscitation was attempted, but then there was no transport.

Paramedics followed protocol and ended the resuscitation attempt or used medical direction to end the resuscitation attempt.

The patient was evaluated to determine that no treatment or transport was required by the EMS clinician, or the patient refused care, whether that was against medical advice or whether it was just refused evaluation and care period, and then the patient was treated and released per protocol.

So those are the most common reasons.

Next slide, please.

So where do the patients go who are being transported?

This is a breakdown based on what the EMS clinician is able to enter today, and it's a slight variation in version 3.5 of NEMSIS that's rolling out right now, and I'll tell you about that in a second.

So the majority of our patients, 24 million, went to the hospital.

That represents just over half went to the emergency department.

The next biggest category is the percent that went, 7.92 percent, that went to the hospital, but the non-emergency department bed.

Now this could be direct admit, this could be any one of the different categories, OB, specific patient going to a specific floor.

The next biggest category obviously is nursing home assisted living facilities, then home.

The other category is really a catch-all of numerous things.

We'd have to investigate that further.

Urgent care centers and freestanding emergency departments.

For example, Maryland had a specific definition for freestanding emergency departments with very specific criteria of where a 911 emergency call could be responded to by an ambulance and transport that patient to that particular facility.

So that's where our patients are being transported to.

Next slide, please.

So then the type of agency submitting records.

So this goes back to the agency type by which the ambulance is responding from.

Fire department-based make up the largest percentage at 45 percent.

So of all those EMS activations that 46 million, 45 percent of those were responded to from fire department-based ambulance services.

Governmental non-fire made up the third biggest category.

I'm sorry, private, non-hospital-based, 27 percent is the second biggest, followed by governmental non-fire, and then hospital-based ambulance services.

Those are staffed by career -- or I'm sorry, I don't want to confuse people.

They're staffed by volunteer or non-volunteer clinicians or a mixed service, where a volunteer service may have paid people for part of the day or on the weekend shifts where it's difficult to get someone or weekday shifts where everybody in the community is working their normal job.

So mixed is that mixture of paid and not paid, and then you have volunteer services and non-volunteer services.

The bulk fall into the non-volunteer or paid services, and then mixed makes up the next biggest category.

Next slide, please.

So the variation based on rural, super rural, and frontier was given to us, but we use the USDA urbanicity codes.

If you look in the graphic with the map, you can see how basically the urbanicity influence codes are lengthy, and we have condensed those down.

That's the small map or the small spreadsheet in the very center.

We have condensed those down into four categories for NEMSIS.

So our clinicians have four options, or I'm sorry, five.

They can say they're a rural service or in a rural area, suburban area, an urban area, or frontier area.

And again, that little XL chart there in the center shows you how we categorize those four.

And then they have an NA, no zip code reported.

No zip code reported most frequently comes for a patient that's in a wilderness setting or on the interstate somewhere where the clinician may or may not be aware of what zip code they're actually in along that long rural stretch of roadway, in the national park, so on and so forth.

So that's why we have the no zip code reported, but we use rural, suburban, urban, and frontier as our categories for NEMSIS, and we can report data out by those categories for you.

Next slide, please.

-Eric, this is Gary.

I have a question on that slide.

-Sure.

-There are many agencies that cover a mixture of those four categories, and I'm wondering how you handled those.

Is it the zip code of where their base station is, their main office where all their records are kept, or did they have the opportunity to say, yeah, we're located in Chicago, but we also cover some of the suburbs and some rural area as part of being the sole responder?

-So the service has the ability to indicate the incident location in its zip code.

So if we're going to classify the services, then we're going to use -- and Clay's on the line, he can correct me if I'm wrong -- we're going to use the address provided for the demographic file of that particular agency.

Is that correct, Clay?

Clay, if you're talking, you're on mute.

You may not be able to unmute.

I will confirm that for you, Gary.

But for the incident itself, we're going off the incident location provided by the clinician, which is why we get the NA, no zip code required.

If it's the demographics, we're going by the initial demographic file created by the agency when they put in their DEM file information to submit data to NEMSIS.

-So is this chart the zip code of the 40 million responses that occurred?

-Yes, this is based on the 46 million EMS activations.

-Oh, okay.

So it's not at the agency level.

-No, it's not at the agency level.

We only have -- 20,000 agencies.

-Okay.

-What Gary's referring to is the agency can get a little hokey.

And I'll use GMR, for example.

Global Medical Response obviously could list one address for all their U.S.

operations.

And that would not be the address you would want to use for all their stations.

So the question then becomes, if you were looking at agencies or actual EMS response stations, you would want to know the zip code for each individual station, not the county's headquarters or the regional program's headquarters.

And Gary is absolutely correct.

When you're looking at that, you have to be very careful when you're running the data for agency location.

But for this particular here, just to make sure I'm not confused, this slide that you're projecting here is where the activation occurred.

-Yes, sir.

So 38 million of the EMS activations of that original 46 ground transports that we started out with are in an urban area by our definition of urban.

Three million are in rural, 706,000 are in frontier, and then suburban makes up the rest.

So I'll address the other three questions, and then I'm happy to take any questions or provide any additional information you're looking for.

There was a question about billing information.

There is an e-payment section in NEMSIS with standardized questions for collecting billing information.

But as I described earlier, billing information primarily stays at the local agency level.

There are only seven states that require agencies to pull that billing information or send billing information from the agency to the state.

And those seven states, and we have an updated slide presentation that will send you with a map that shows this, but the seven states that require agencies to pull that billing information from the agency are Colorado, South Dakota, Alabama, South Carolina, North Carolina, Massachusetts, and Maine.

They require some or all of the e-payment section in the Data Dictionary of NEMSIS to be sent to the state from the agency level.

The other 43 states and territories and D.C.

do not.

So there was another question then, is that a hard, fast rule, or do agencies submit data to the state and they just don't use it, or it's kind of like a soft submission?

I'll use it as kind of a bad term, but that's the question.

And the answer is no.

If the state doesn't require them to send it, their data system is not set up to accept it, so they either fall into the category of one of the seven who will take it, or the others who do not.

So there isn't another way to get to it.

And I think that was the end of the questions that were submitted to us initially.

I am happy to address any questions you have.

I do want to make one comment based on what I heard earlier.

The definitions that you're working on are key and critical.

I would just ask that you keep one thought in mind.

And I'll use the definition of implied consent that GAM mentioned earlier.

Implied consent is clearly defined in the -- and I have it here in front of me, the AOS textbook.

I just happen to have that one available.

And I'll tell you why that's important, because the clinician is making the decision based on that definition and recording the data in NEMSIS based on that definition.

And the NEMSIS data element was originally established for the clinician, so it's following that definition as well.

And we've seen this with when we look at statutory definitions, there's often conflict and no greater example exists than emergency or non-emergency transport.

The definitions in statute for emergency and non-emergency in some states, or the requirement of lights and sirens, are often being interpreted in billing and billers as a definition of emergency and non-emergency.

So as you establish your definitions, I would just ask that you think about what the clinician is going to be looking at in coding and reporting and making their decision based on as you develop yours.

Questions for me about NEMSIS, other data that you would like to see?

Tell me what you would like to get to, and we'll do everything we can do to get you that information.

-Eric, thank you so much for that presentation.

-I already see several committee members have their hands raised, and then we are now opening up the chat to the public as well to ask questions.

So I will start with Patricia.

-Yes, thank you very much.

So I wanted to talk a little bit about that treatment in place slide that you had there.

So I think you summed it up by saying about two million folks are, based on your data, are treated in place.

And I believe you may have answered this when you had come before to one of the subcommittees.

Can you talk a little bit about what kinds of treatment that is, and do you have a breakdown of that?

Like, what kinds of treatment?

And so, we just have a sense of, like, how much resources are being used by our ground ambulances, either in terms of time and energy and expertise and/or supplies for those treatment in place.

-Yes, ma'am.

If the person running the slides could go back a couple, I'll tell you when to stop.

So we can do a little bit of more detail on what's in -- let's see, back up.

I'm sorry, go back to the previous slide, the one you were just on.

Go back, please.

-I think it's the next one.

-No.

Back one more, please.

Keep going.

Keep going.

Go to the other.

I'm sorry, go the other way.

-That one.

-That one, that's it.

So yes, we can go back and look at the primary reason for encounter and determine, you know, what the initial call was for and determine what the breakdown for that is.

I can put that on the list and get that for you.

It's not a problem.

I will tell you that not all of the treatment in places are captured here, at least by my perspective, and Gary may be able to speak to this as well.

For those EMS -- well, that's going to muddy the waters.

Never mind.

For the EMS activations that we're talking about, the 46 million, the treatment in place that's provided are listed here in that 3.6 percent and 1.71 percent.

And we can go back and look for the reason for dispatch and primary reason for encounter and what the clinician's primary impression was and get you a better understanding of what that call was about.

-Does that answer your question, Patricia?

Do you have a follow-up?

-No, that's great.

Thank you so much.

-Okay.

Rhonda.

-Hi.

Thank you very much for this presentation.

My question was kind of along the same thing as Patricia.

These numbers for non-transport seem very, very low to me.

And is this an area where maybe the ambulance provider doesn't fill out the question?

You said that some of them, they don't have to fill out all the questions.

So I was just curious about that.

-So each one of the patient encounters listed here of this 46 million resulted in a patient care report being generated.

So then for the non-transports, we could look at the other category and see if there's something glaring in there.

But these are all accounted for as an activation somewhere in NEMSIS.

So we can break it down further and see, again, kind of the same lines, what some of these categories were.

Are there specific ones you're interested in?

-Yeah, I don't think I have any specific that I'm interested in.

I just think the overall numbers are quite low.

-Okay.

So we know from the 46, 33 were straight up patient was treated and transported by EMS.

So that leaves us with 13 million activations that we want to look at more specifically.

I'm assuming that standby, public safety, fire, EMS, operational support is not something you're interested in a breakdown on.

But you would like to know for those specifically two categories, patient treated and released and patient treated and released per protocol and AMA, what the breakdown, were they cardiac patients?

Were they motor vehicle crashes?

In the example that I gave you, were they diabetic patients?

Were they opioid patients where Narcan was given and the patient refused transport then?

We can certainly give you a better breakdown of those.

-Falls and things like that.

And I think it's getting towards supporting community paramedicine, because these calls might've been able to be handled by community paramedicine instead of a ground ambulance and kind of some supporting data on being able to ask that those community paramedicine services be provided.

-Yes, ma'am.

And I think that there -- this is pure speculation on my part.

I think a large portion of these categories -- not large portion, I think there's a significant portion of those patients fall into that 33 million category there because they're just transported because that's the way the services get paid.

That's what I've been told.

-Perfect.

And I think right now, the data that we're looking at based upon our charges, patients and consumers, but right now your data showing 33 million patients are being transported by ambulance to some location based upon what you indicated.

Whether they should have gone that way or not, I don't think is the charge of our committee yet, but this is what that is showing, correct?

-You're absolutely correct.

-Fantastic.

-This slide shows if they were transported and the next slide says where they were transported to.

-Excellent.

Ted, I think you have a question.

-Yeah.

And I just think it's, as you get into this, you see resuscitation attempted, you know, those are actually taking care at the scene, or treatment in place so that you need to bring that into the number also or any one of these categories where you're actually treating.

I think that just gives a better scope of, you know, obviously there's a cost piece to that.

We all know when a resuscitation like that is quite a bit of effort to make that happen and a lot of equipment and a lot of time, rightfully so, just to try to save somebody like that and then potentially being pronounced at the scene under protocol.

So I just think you want to wrap in anything that is a treatment of an EMS at a scene that then does not result in a transport, just as a thought there.

-And Sean, I see you have a question or comment.

-Yeah, I guess I just kind of follow up with what Ted said, which is basically when we look at this, we see a 27 percent rate of something happened other than a transport.

73 percent of the calls result in a transport.

Those are the ones, the 73 percent are the ones that potentially generate some kind of revenue.

So when we go back to the discussion we had earlier this morning about the Medicare cost data collection efforts and everything else, that really it's the whole global set of the things you see listed that are the true cost drivers.

Yes, there's a lot of little subcategories here and everything else, but in order to be in place and ready to respond, regardless of which result other than the 73 percent that got an ambulance transport, that cost structure had to be in place for it.

-Sean and Ted, you're absolutely correct.

I would also move in patient evaluated no treatment and transported.

The assessment was completed and the patient was determined to not need transport.

Certainly, all of the categories of patient treated, whether they were transferred to another ambulance or transported by EMS or transported by law enforcement, any of those where the patient was treated certainly drive costs.

Because as you said, someone really cost is driven by activation.

Somebody responded to all of these 46 million responses.

Right?

If you want to look at it by peer cost, somebody was sent to 46 million EMS activations.

33 million resulted in direct transport to EMS, but the remaining 13 million still had something done by EMS, or EMS had a role with that particular incident if there wasn't a patient.

It wasn't an option for them not to go, I guess is the way I'm trying to say.

-Eric, I have a question for you as well as kind of a follow up to a few of the committee members here.

-Sure.

-The 33 million that we have in an actual transport occurring, so I have an additional 13 million that you've broken up into several of these different categories.

Just as a point of clarification, the qualifier is that an electronic patient care report has to be submitted for the data to trigger to the state to trigger to this database, correct?

-Correct.

-Okay, so as long as an electronic patient care report is provided, then it's going to be reflective in these numbers.

And I know I keep reiterating just for the public's perspective, just to try to break it down in plain English.

-You are correct.

If an ambulance went out for whatever reason and provided care but never generated a patient care report, we would not know about it.

-You would not know.

Perfect.

And so the additional 13 million that we have going on here, is there a way for you to bifurcate that database?

Because since this is an actual assist that they're calling out an assist we sometimes could have maybe numerous assists happen to the same patient.

Can you bifurcate that data down to that level or no?

-Let me take a look.

Let me start with why the assist occurred and then try to take it to the patient level, if there was a patient.

There may have not been a patient in those first three categories.

It may have been a response.

But again, if that response is to assist another agency at a scene as part of a motor vehicle crash with a lot of motor vehicles involved or something, you know, we'll be able to get to whether there was a patient or not a patient.

And then the second part of the category is, I mean, it's still going to your cost.

Again, it wasn't an option to not respond.

But let us get some greater specificity on breaking down these particular categories as requested, and maybe that'll help.

Once we look at it, then we'll look at the incident, and then we'll try to get to the patient level as well.

-Sure.

And right now what we're looking at, cost in one factor, and then what that does to drive the price.

And we'll get into the definitions of that, which is that technically oftentimes the bill charge that a consumer will receive when there's not a patient contact made.

So that's all, of course, put into the price or the cost of the service.

What I'm really interested in seeing is it like in three different buckets.

Where was there no patient contact?

There was an assist.

Same patient.

If we can provide that where there was nothing -- one, where there was contact made with the patient regardless, kind of to Ted's point and others, if they were dead on scene, even if they arrived on scene, maybe they didn't see the patient, patient was declared dead at that point in time or before they arrived on scene.

And then where they actually made patient contact and there was no subsequent transport.

The 33 million is obviously there, but I'd love to see if we could kind of put that into maybe three buckets, maybe four.

You may have a fourth bucket in that 13 million.

So we can kind of understand this drives cost.

Consumer may have received the bill, depending upon certain practices of each of the individual agencies.

If they actually made contact with no transport, sometimes consumers get bills for that, sometimes they don't, just so we can understand the behavior pattern.

-Okay.

And then when we're doing this, how interested are you in the rural, urban, suburban and frontier?

-Very interested.

That would be very interesting.

The way that you broke that down to me is very interesting.

I don't know about the other committee members, but that would be very interesting to me.

-Very interesting.

-Rhonda.

-Just another question here for you.

Of the seven states that require billing information to be submitted, would it be worthwhile for us to see some of that data broken down?

Would that help the committee?

-So just a point before you get too far.

So we do not take that data at the national level.

So we would have to reach out to the state, which we would be happy to do, and say, could we work on behalf of this committee to run some basic analytics on the billing data that you have to see what's available, to see what could support the committee's work?

And we're happy to do that, but we'd need a little bit more direction on specifically what you're looking for beyond what data do you have, what's your interest?

-I'm assuming that the e-payment dictionary that you have available, is that available, what those elements are?

Is that in the the enhanced slide presentation you'll be giving to us?

-Yes, sir.

Well, yes.

It'll have the link of where to go to get to those, but if you go to the data dictionary that's available at nemsis.org, it will have a very specific breakdown.

Every element is clearly defined and the attribute associated with the element is clearly defined.

So you'll be able to see, for example, the insurance information is collected, the billing information, or the insurance type, the social security number, in some cases, those types of fields are defined in the e-payment section.

-Okay.

Ritu.

-Yeah, just two, I guess, quick points.

Back on the whole cancelled prior to arrival, I mean, a number of my agencies don't do a chart.

I mean, the only place to get that number is really straight from CAD data.

So that would be, you know, one, we're always going to underestimate the number of times an ambulance or fire engine or fire apparatus was cancelled prior to arrival.

And then with regards to the point around cost of treat in place, just sort of delving into like how much was spent and et cetera, one, I just wanted to reinforce that, yes, cardiac arrests that are not transported are a significant time and expense, and they need to be included in that discussion.

But also that moving forward, if treat in place becomes more pervasive, that the costs that we look at from 2022 may not reflect costs if it becomes more pervasive in the future.

I would expect sort of more things to happen prior to being left in place.

-So at the National Association of State EMS Officials meeting in last year, or I'm sorry, this year, we proposed expanding this data set for more treatment in place information.

That is, we respond to really NSEMSO as the kind of, not the owner, but -- well, in some ways the owner of this particular product.

And if they want us to expand this to account for treatment in place, we're happy to do so.

But you are absolutely correct, sir.

This was designed, NEMSIS was designed to capture the emergency 911 response.

Over the years, it has morphed into capturing more information on inter-facility transport, on helicopter transport, and fixed wing transport, and some critical care.

And I see that happening quite honestly, but that's the question that's proposed to NSEMSO's leadership now is to what expansion NEMSIS should take on to accommodate more treatment in place data for the purposes you're talking about right now.

And one quick example, ET3 added to the disposition list in version 3.5 alcohol and drug rehab facilities as a transport destination.

And that was added specifically as a part of the ET3 model to meet that possibility for billing purposes.

So that's a good example of just responding to the changes in the environment in which EMS is functioning.

-Gary, I see your hand is raised.

-Yeah, I agree that having the payment side information available would be good for us.

And when you ask the states if there's a way, or maybe when you get the data and have zip codes, maybe there's a way to break those down by urban, suburban, rural, and frontier, so we can see if there's any patterns regarding insurance payments across the various sectors.

-So just as a point of clarification for the payment data that's available, in my understanding, in Colorado, South Dakota, Alabama, South Carolina, North Carolina, Maine, and Massachusetts.

Did I get those states right?

I was writing fast.

-Yes, sir, you have them.

-And we'll go look at the data dictionary of the information.

From your understanding, while I know it's not reported from the state level to the federal level at this point in time, are they capturing all elements as defined in the NEMSIS database, or is that a question you don't know?

-I don't know, and the answer could vary from state to state.

So that would be one question we would ask is, what are you collecting, and then do the comparison.

We can see what states collect what data elements at the NEMSIS-TAC, so we can take a look at it first from our level, and then get to the granularity that you're seeking.

-I guess that would probably be the first thing that I would ask, to even see if they're collecting enough data that would even be even relevant from those seven states that we could make any type of conclusive recommendation or finding in our final report.

If that's something you guys have the ability to do, Eric, or if that might be something we have to ask somebody else to do.

-Yes, sir.

We can do that work.

-Okay.

-What I would need, or what I would ask from you is, certainly I understand the question of what data is collected, who collects what elements, and then comparing the states, but what is it that you would really like to know?

I hear Jonathan Washko in the background, begin with the end in mind.

Tell me what it is that you want to know.

You want to know how many ambulance services -- we'll pick Colorado, just because they were first on my list.

Within the state of Colorado, how many ambulance services are billing?

And of those ambulance services that bill, what's the breakdown of the types of calls that they're running, or where they're transporting to?

That's what I would need to know to help you get to what you're looking for.

-There was a question in the chat from the public as well, asking if you've broken data down by region.

And if you have, how do you define the regions?

-And that's what I was going to say.

Regions are like pediatrics.

Everybody asks for pediatric reports.

You want pediatric by -- we use elementary, middle, and high.

At NHTSA, we use pediatric definitions based on what fits into a safety seat, a seat belt, the weight.

We use NHTSA regions, FEMA regions.

It just depends.

We can do regional data.

You tell me what the regions are that you want to look at, and we can certainly do a regional report.

It's just whose definition do you want to use?

-Any questions for Eric while we have him here from the committee?

Any more public comment on data that you might particularly find useful?

I will tell you, we'll probably reconvene at our next meeting to see what other data would be -- as we continue to look at certain other components into the next half, Eric, I'm sure we'll be getting back with you on some of that data as well.

I see, Patricia, you've got a question.

-Yeah, thanks.

I just wanted to ask, I believe that you said this was reflective of 2022 data.

And so, I just wanted, you know, not knowing what happened, you know, pre-pandemic and knowing that COVID kind of has spilled into 2022.

Do you have a sense of, like, this is reliable, like, somewhat normal numbers that we would see?

So you know, we're using, obviously, this data in our analysis.

So just wanted to see if you had any flags for us on that.

-So we're looking at, and I'll just pick motor vehicle crashes, because we're NHTSA.

We have a report that we run called EMS by the Numbers, and we look at motor vehicle crash activations, for example, on a weekly basis.

And we look at the pre-COVID years, we call it 2018 and '19.

And in 2020, we see the big spike when the president made the announcement and we started to see a decline in states closing.

We saw motor vehicle crashes, the numbers plummet, but we saw the ejections just go the opposite direction, because people were driving faster, there was no one on the road, reckless driving, unbelted, whatever.

And then things kind of, you know, stayed up for all of 2020 and the bulk of 2021.

We saw the same thing for cardiac arrests at home.

In fact, the American Heart Association worked with us on their Don't Die in Doubt campaign, because we looked at some large urban areas where the numbers of people dying in their homes just increased dramatically, because they didn't want to go to the hospital, because that's where the COVID was.

At least that's our speculation.

So we can look at data 2018-2019 compared to 2022.

And we can also look at 2023 to -- we use a two-week buffer, we have about 85 percent of all the reports that you're going to receive in the U.S.

in about 72 hours now.

COVID has cut down that reporting timeline.

This data is extremely timely.

So we can look at the first part of 2023, but I'm fairly confident that we're not going to see anything different between the first six months of 2023 and what you see now for all of 2022.

-Thanks.

-Asbel, this is Gary.

Just a quick comment.

I apologize for not raising my hand, but I want to, of course, thank Eric for the presentation on NEMSIS.

He just spends really innumerable hours helping to manage this national system.

And, you know, as he mentioned, it's a very close, collaborative, long-term effort with the state and territorial EMS offices as well as all the way down to the clinician level folks who are actually collecting the state data patient side.

You know, as we look at the data, I would just, you know, encourage us as we have questions about particular states to work with Eric and to reach out to the individual state EMS offices as well, because they really offer a valuable perspective about the data collection as well.

-And again, number one is from the committee's perspective and chair, and I know from others, we're very, very appreciative for NHTSA presenting several times on this dataset as well.

I'd like to just make one comment, though, just for the public that's listening in as well.

And this goes to Eric's point and some of the stuff that we continue to talk about that data is only good as what you input into it.

And so, if an EPCR, if you don't bill for services, for instance, or as Dr. Ritu indicated here as well, that in where he's the medical director, they sometimes don't bill for a response.

And so, there may not be a medical record or there could be an assist.

And I think some committee members were getting at that as well.

And so, if we're looking at this to see, can you substantiate the cost of a service, this data set may not be totally inclusive of all of that to come to a conclusion that this is all of the activations that EMS does across the nation.

But what it does allude to, which I think provides a benefit, is how many activations may be resulting in some type of billing occurring.

And because we are part of the No Surprises Act, and that's what we're looking at, this potentially has the ability to at least show some of that that might be going on as we continue to deliberate on into the next few months, specifically around some of the other data, Eric, that you and your team will hopefully continue to be able to provide to us around the treatment in place, the AMAs or the Against Medical Advice, the patient refusals, different things like that, that potentially could result in some type of bill to a consumer that may not necessarily be covered by an insurance carrier, or may be covered and results in a balance bill as well.

Any other questions from the committee?

I'll see if we have any more public comments.

I know every public comment will be reinforced.

We do have a few more minutes here before we do break.

So I do want to give time for the public to have input as well as the committee while we have the individuals from NHTSA and NEMSIS here.

-Asbel, just one quick question from me, and it's based on one of the comments in chat, which is how many ambulance services bill?

How significant is getting to that number for you, or is it what they're billing for?

Because it is very difficult to figure out how many actually bill.

We may be able to look at that at a state level, but nationally, that's a significant -- it's a very tough question to get to.

-And I think that's another really good point, Eric, you just made.

I know there was one last public comment that did make when we're talking through and continuing to deliberate on in the next several months regarding payer information, insurance information that might be through some databases.

Oftentimes, this commenter noted that sometimes the information is outdated, may not be subsequently updated into, so perspective is going to be important when we're looking at billing information.

So we'll do a deep dive.

Interesting to see the information, Eric, that you're able to come back to the committee on specifically around that e-payment system and what is actually available out there and what they're reporting on.

That might help aid some of our additional questions that we might have for you in relation to the actual elements.

While all elements are available and we can see that on NEMSIS, are they using all elements or is it just certain elements to see if we can even drive some questions to you that you might be able to decipher out of the data.

Any other comments?

If not, I'll turn this over to Terra.

We might get a few more minutes of our lunchtime or whatever.

Terra?

-Thank you.

Today's agenda and a list of the public comment topics are available for download in the chat window.

We will now take a midday break and resume at 1:30 p.m. Eastern time.